STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 03/25/2011
	ROVIDER OR SUPPLIED	R 'ING COMMUNITY LLC	3525 E	HANNA AVE APOLIS, IN46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG F0000	This visit was for State Licensure	or a Recertification and Survey. March 21, 22, 23, 24 & 25, 1000103 11: 155196 100290000 N TC N 123 & 24, 2011) N 124, 2011)	F0000	DEFICIENCY	
	Census bed type SNF/NF: 69 Residential: 56 Total: 125 Census payor ty Medicare: 6 Medicaid: 39 Other: 80 Total: 125 Sample: 15 Residential sample: 15	pe:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9S2F11

Facility ID:

000103

TITLE

PRINTED: 04/19/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	LETED
		155196	B. WING			03/25/2	2011
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN46237		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	These deficienci	ies also reflect state					
	findings in accor	rdance with 410 IAC 16.2.					
	Quality review of Cathy Emswille	completed 3-29-11 r RN					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THINDTEME	or correction	155196	A. BUII			03/25/2011
		100.00	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF P	ROVIDER OR SUPPLIER				E HANNA AVE	
AI TENHE	IM HEALTH & LIVI	NG COMMUNITY LLC		l	NAPOLIS, IN46237	
			-		1	1 (7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
F0248		ation, record review, and	F024	18		04/24/2011
		ility failed to ensure	1 02		This plan of correction is to	0 1/2 1/2011
SS=D		ty programs were			serve as Altenheim Health an	d
	•	dents who were room			Living Community's credible	
	•	ast. This affected 2 out			allegation of compliance.	
		ewed for activities in a			Submission of this plan of correction does not constitut	
					an admission by Altenheim	-
	sample of 13. (Residents #42 and #21)				Health and Living Community	,
	Piudi 1 1 1				or its management company	
	Findings include:				that the allegations contained	•
					in the survey report are a true	I
		cord for Resident #42			and accurate portrayal of the	•
	was reviewed on 3/22/2011 at 3:22 p.m.				provision of nursing care and other services in this facility.	I
					Nor does this submission	
	Diagnoses for Re	esident #42 included, but			constitute an agreement or	
	were not limited	to, dementia, paralysis,			admission of the survey	
	osteoporosis, stag	ge 4 pressure ulcer,			allegations.	
	coronary artery d	isease, chronic kidney			F248-483.15(f)(1)	
	disease, and chro	nic obstructive			ACTIVITIES MEET INTERESTS/NEEDS OF EACH	<u> </u>
	pulmonary diseas	se.			RES	
					I.	
	A review of Resi	dent #42's quarterly			Resident #42 & #21 are now	
	assessment dated	3/3/2011, stated the			receiving appropriate activities	of
	resident, "passive	ely participates in various			interest including sensory stimulation, and their care plan	s
	· •	s on the unit; however,			have been updated.	·
		s visiting with her			II.	
		its at least 3-5 times a			The facility has reviewed activi	ty
	week.				programs for all residents who	
	· · · · · · · ·				are room confined or bedfast. Specialized programs have be	en
	A review of Resid	dent #42's activity			put into place where appropria	•
		ch 2011 indicated the			and the care plans have been	
		resident was involved in			updated.	
	was visits with he				III.	.
	was visits with no	zi iaiiiiy.			The systemic change will be all residents who are room confine	
	To an interest	.:			or bedfast will have an	
	In an interview w	vith the Unit Manager of			To Sound this Have all	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DING 00		(X3) DATE SURVEY COMPLETED					
ANDILAN	OF CORRECTION	155196	A. BUI	LDING	<u></u>	03/25/2			
		133190	B. WIN			03/23/2	011		
NAME OF I	PROVIDER OR SUPPLIE	2			ADDRESS, CITY, STATE, ZIP CODE HANNA AVE				
ALTENH	EIM HEALTH & LIV	ING COMMUNITY LLC		1	IAPOLIS, IN46237				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	1	/2011 at 4:00 p.m., in			interdisciplinary review of their				
	regards to Resident #42 activities outside				activity plan of care with interested family members dur	ina			
	of the resident's room, she indicated the				their quarterly review and as	ıı ıg			
	only time the resident left her room was				needed with changes.				
	during the meal times.				Education will be provided to				
	In an interview with the person in charge of activities, on 3/24/2011 at 3:21 p.m.,				activity staff regarding specialize	zed			
					activity programs for residents who are room confined or				
					bedfast.				
		at she had not tried any			IV.				
	other activity wi	·			The Administrator or the design	nee			
					will review the activity				
	Observations of	Resident #42 on			documentation and observe th	е			
	3/22/2011 at 4:10 p.m., 3/23/2011 at				activity for a random 5 room confined or bedfast residents p	ner			
	1	•			unit weekly for 4 weeks, then	,01			
	10:10 p.m., 3/24				every other week for 4 weeks,				
	1 1	d 3/25/2011 at 10:00 a.m.,			then monthly for a total of 12				
	1	in bed with no television,			month of auditing/observation.				
	1	family, friends or care			Any identified concerns will be addressed.				
	givers present.				The results of these reviews w	ill			
		10 5 11 1/21			be discussed at the monthly				
		ecord for Resident #21			facility Quality Assurance				
	was reviewed on	3/22/2011 at 11:47 a.m.			Committee meeting and				
					frequency and duration of reviewill be adjusted as needed.	ews			
	1	esident #21 included, but			Completion date: 4/24/11				
	were not limited	to, osteoporosis,			F				
	hypothyroidism,	dementia, and left breast							
	cancer.								
	A review of Res	ident #21's quarterly							
	assessment dated	d 1/19/2011, stated the							
	1	pates in independent							
		self direct her leisure							
	1	refers her own company."							
	A review of Res	ident #21's activity							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE : COMPL 03/25/2	ETED	
	PROVIDER OR SUPPLIER	II : ING COMMUNITY LLC	STREET A 3525 E	NDDRESS, CITY, STATE, ZIP CO HANNA AVE APOLIS, IN46237	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	March 4th the or participated in w March 1, 2, 3, an indicated the resi active games, car aerobics, exercis movie and popco. In an interview w of activities, on 3 she indicated the wanted. When it massage therapy being offered to that it had not be. Observations of at 4:50 p.m., and she was sitting at were 3 other resi She did not say a of the care givers. Observations of at 3:25 p.m., and she was in bed w	Resident #21 on 3/22/11 3/23/2011 at 8:45 a.m., the table eating. There dents sitting with her. anything to them or to any				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING				(X3) DATE COMPI 03/25/2	LETED			
	NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN46237				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE		JLTIPLE CC	TIPLE CONSTRUCTION (X3) DATE SURVI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155196	B. WING			03/25/2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			l	HANNA AVE	
ALTENH	EIM HEALTH & LIVI	NG COMMUNITY LLC		1	IAPOLIS, IN46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF COR		NEOWINERS N. AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG CROSS-REFERENCED TO THE		DEFICIENCY)	DATE
R0273	Based on observa	ation and interview the	R02	R0273 R273-410 IAC 16.2-5-5.1(f)		04/24/2011
	facility failed to ensure that food was				FOOD AND NUTRITIONAL	
	-	d, raw hamburger was			SERVICES – DEFICIENCY	
		boxed turkey, facial hair			l.	
	_	• •			The bag containing fruit salad	
	·	I failed to ensure that			was discarded upon discover	у
		not growing on the walls			during the survey.	
	in the dietary department. This has the				The bowls of grapes, apple sauce and angel food cake	
	potential of affec	ting 56 of 56 residents			were discarded upon discove	rv
	who reside at the facility. Findings include: During the tour of the facility's kitchen				during the survey	
					The mold on the wall to the	
					right of the dishwasher was	
					immediately removed and	
					cleaned during the survey.	
	•	he Dietary Manager on			The box of turkey was	
		_			immediately discarded and th	ie
		00 a.m., the following			cooler was rearranged	
	observations wer	e made:			appropriately so that no raw	
					meat was thawing above other	er
		frigerator, a gallon size			The scoop was removed from	,
	zip lock bag cont	aining what appears to			the bulk container of sugar a	
	be fruit salad, did	I not have a date on it.			the sugar was discarded.	
					Employee #1 and #2 were	
	b) In the tray line	e refrigerator, there was 3			immediately educated on	
	· ·	, 5 bowels of apple			sanitary conditions and now	
	• •	es of angel food cake, that			have any facial hair	
	was not covered				appropriately covered.	
	was not covered	or dated.			.	
	a) Tha11 / - /1				All opened food items are not appropriately covered and	"
	*	e right of the dishwasher,			dated.	
		dishes are loaded are			The walls in the dietary	
		nachine, there was black			department have been cleane	d
	mold growing on	the wall.			and are free of black mold.	
					All foods in the cooler are	
	d) The cooler loc	ated downstairs, had raw			arranged appropriately so tha	nt
	· ·	ng over a box of turkey.			no raw meat is thawing above	•
	<i>5</i>				other food items.	
					!	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPL 03/25/20	ETED	
	PROVIDER OR SUPPLIEF	ING COMMUNITY LLC	3525 E	ADDRESS, CITY, STATE, ZIP CODE E HANNA AVE NAPOLIS, IN46237	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
	f) Employee #1 a facial hair that is During an interv Manager, on 3/2 indicated the bla	and Employee #2 had not covered. iew with the Dietary 5/2011 at 9:40 a.m., she ck mold was cleaned off vening of 3/21/2011 with		Scoops are not left in bull containers of sugar. Employees with facial hai have their hair covered appropriately III. The systemic change incl a schedule of dietary staff assignments for daily checklists to include the Dietary Manager to hold accountable for the check Any newly hired kitchen swill be trained on the daily checklist during orientation. The cleaning schedule habeen reviewed and revise include the items listed al Education was provided folietary staff regarding the dating and covering of opfoods, cleaning schedules the dietary walls, arrange of foods appropriately in cooler so that no raw meathawing above other food items, scoops are not left bulk containers, and propic covering of any facial hair. The Director of Dining Seor designee will complete daily audit, 5 days a week proper storage and dating opened foods, cleaning ovisual checks of the dietard department for molds, procovering of facial hair, no scoops left in bulk containand appropriate arrangement and appropriate arrangement.	udes with taff list. taff on. s d to pove. or all ened s for ment the t is in er or of and ry oper	

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AND PLAN	NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN46237		(X3) DATE SURVEY COMPLETED 03/25/2011	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				of foods in the cooler so that no raw meat is thawing above other food items. This audit will continue for 30 days, and then will be completed 2 days week for an additional 60 day then one day a week for an total of 12 months of monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. Completion date: 4/24/11	e d s a /s,	

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NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN46237 (X	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURY A. BUILDING B. WING (X3) DATE SURY COMPLETE 03/25/2011			ETED		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X				B. WIN	STREET A 3525 E	HANNA AVE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT	PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE
F0279 SS=E Based on record review and interview the facility failed to ensure care plans were developed based on residents' comprehensive assessments for communication, pain, behaviors, dehydration, oral care and vision for 5 of 13 residents reviewed for having care plans based on their most recent comprehensive assessments in a sample of 15. (Residents #51, #54, #22, #42 and #21) Findings included: 1. The record of Resident #51 was reviewed on 3/22/11 at 4:30 PM. Diagnoses for Resident #51 included, but were not limited to, arterial insufficiency and history of a cerebral vascular accident. (CVA) An annual Minimum Data Set (MDS) dated 2/18/11 indicated Resident #51 had minimal difficulty hearing. The Care Assessment Area (CAA) of Communication indicated "Resident triggered this CAA related to minimal hearing deficitHas some word finding, thought processing problems related to CVACare Plan DecisionYeswill continue to communicate needs" A review of the resident's care plans F0279 F279-483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLAN. I. Resident #51 now has a care plan in place for behaviors. II. Resident #51 now has a care plan in place for behaviors. II. All residents *21 now has a care plan in place for behaviors. III. All resident #22 now has a care plan in place for behaviors. III. The verence of dehydration, oral care and vision have been reviewed and care plans based on the resident needs and assessment have been developed as needed. III. The systemic change includes: An interdisciplinary care plan conference will be held within 7 days after the completion of the comprehensive assessment and the conference will include an audit of all care plans relating to the triggered care		facility failed to developed based comprehensive a communication, dehydration, oral 13 residents reviewed and history of a caccident. (CVA) An annual Minimum dated 2/18/11 incomminal difficult Assessment Area Communication triggered this CA hearing deficitI thought processin CVACare Plan continue to communication triggered to communication triggered to communication triggered this CA hearing deficitI	ensure care plans were l on residents' ssessments for pain, behaviors, care and vision for 5 of ewed for having care neir most recent ssessments in a sample of 51, #54, #22, #42 and d: Resident #51 was 2/11 at 4:30 PM. esident #51 included, but to, arterial insufficiency cerebral vascular mum Data Set (MDS) dicated Resident #51 had by hearing. The Care of (CAA) of indicated "Resident of the Care	F023	79	COMPREHENSIVE CARE PLAN. I. Resident #51 now has a care plan in place for communication. Resident #54 now has a care plan in place for pain. Resident #21 now has a care plan in place for vision. Resident #42 now has a care plan in place for dehydration. Resident #22 now has a care plan in place for behaviors. II. All residents' most recent comprehensive assessment and triggered care area assessments for communication, pain, behaviors, dehydration, oral care and vision have been reviewed and care plans base on the resident needs and assessment have been developed as needed. III. The systemic change includes: An interdisciplinal care plan conference will be held within 7 days after the completion of the comprehensive assessment and the conference will include an audit of all care plans	ed	04/24/2011

000103

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155196	B. WING		03/25/2011
			_	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R.		5 E HANNA AVE	
		ING COMMUNITY LLC	IND	ANAPOLIS, IN46237	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG		DATE
		d not been developed for		area assessments.	
	communication related to her hearing deficit.			Education was provided to the	1e
				MDS Nurses regarding the completion of care plans wh	on
				triggered by the Care Area	žII
	Further informat	ion was requested from		Assessment.	
		Jursing (DON) on 3/22/11		IV.	
		ding Resident #51 not		The Unit Manager, ADON	
	having a communication care plan.			and/or DON will audit for	
		meation care plan.		completion of care plans as	
	_ · · · ·	. 2/22/11 / 10.00		triggered by the care area	
	During an interview on 3/23/11 at 10:00 assessment after the				
	am the DON indicated a communication			completion of a comprehens	ive
	_	t been created for the		assessment. This audit will	
	resident. He pro	vided one dated 3/23/11		include 100% of all comprehensive assessments	
	addressing the re	esident's hearing deficit.		for 3 months, then 2 per unit	I
				every month for an additiona	
	2. The record of	Resident #54 was		months.	
	reviewed on 3/22	2/11 at 10:50 am		Any identified concerns will	be
	10 / 10 / / 04 011 0/ 22	7 11 00 10.00 0 0		addressed.	
	Diagnoses for Re	esident #54 included, but		The results of these reviews	
	1 -	to, history of a fractured		will be discussed at the	
		•		monthly facility Quality	
	1 * '	stasis ulcers and chronic		Assurance Committee meeti	- 1
	renal disease.			and frequency and duration reviews will be adjusted as	
				needed.	
		for the resident, dated		Completion date: 4/24/11	
	· ·	d she experienced pain		· ·	
	"occasionally" as	nd rated her pain at a "5"			
	on a "zero to ten	scale." The CAA of Pain			
	indicated "Reside	ent reported during staff			
		e experiences occasional			
		a scale of 1 - 10. Stated			
	pain interferes w				
	1 ~	Plan DecisionYeswill			
	indicate pain reli	e1			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 03/25/2	LETED
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC			3525 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE NAPOLIS, IN46237		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	indicated one had pain. Further informathe DON on 3/2 Resident #54 no pain. On 3/23/11 at 10 indicated a pain developed for the pain.	resident's care plans and not been developed for tion was requested from 12/11 at 6:02 PM regarding of having a care plan for 0:00 am the DON care plan had not been the resident. At this time ain care plan for Resident 11.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011			
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN46237				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		3 NATE	(X5) COMPLETION DATE
F0282 SS=D	facility failed to dand care plans we residents reviewed physician's order sample of 13. (Ro Findings include The clinical recorreviewed on 3/22 Diagnoses for Rewere not limited osteoporosis, stage coronary artery disease, and chropulmonary disease. A recapitulation of dated 10/19/2011 was to have a 16 with a 10 millility. A care plan for R indwelling urinar problem and apprindicated that the 16 French cathete balloon per the M A nurse's noted distated,"removed	rd for Resident #42 was //2011 at 3:22 p.m. resident #42 included, but to, dementia, paralysis, ge 4 pressure ulcer, isease, chronic kidney nic obstructive se. of physician's order, indicated Resident #42 French foley catheter er balloon. resident #42, for an ry catheter, with a roach date of 9/15/2010, resident was to have a er with a 10 milliliter fD order.	F028	32	F282-483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN I. Resident #42's order for the Foley Catheter was clarified with the physician during the survey and an order was obtained for the correct size and the care plan was updated. In addition, the flor requirement and bowel incontinence care plan was updated and is being follow II. All resident's care plans are being reviewed for physicial orders and care plans being followed at a rate of 10 resident's care plans have been reviewed. Adjustment will be made as needed dur the review process. In additionall dehydration assessment will be reviewed and care plans have been reviewed and have been reviewed have bee	ed. sing ion, sans des	04/24/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED			
l		155196		LDING		03/25/201	
100.100			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	HANNA AVE		
ALTENHEIM HEALTH & LIVING COMMUNITY LLC				INDIAN	APOLIS, IN46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		re C	COMPLETION DATE
IAG	\	ed it with new 14 French	1	IAG	and the care plan will be	DAIL	
		th 30 milliliter of sterile			adjusted as needed.		
	water per sterile				Education will be provided fo	r	
	water per sterile	technique.			nursing regarding updating the		
	Δ nurse's noted d	lated 3/16/2011, stated,			plan of care with new physici	an	
		ley catheter 16 French			orders and with the quarterly and as needed dehydration ri	sk	
		balloonnew 16 French			assessment.		
		aced via sterile technique			IV.		
	with 30 milliliter	_			Unit Managers or designee w audit 100% of new physician	iII	
	A care plan for Resident #42, for bowel				orders for completion of care		
					plan and 100% of care plans		
incontinence, with a problem and approach date of 9/24/2011, indicated the				after completion of the			
				quarterly and as needed			
	resident was to receive a minimum of 1275 milliliters of fluid per 24 hours. A vital sign report for Resident #42 plus a				dehydration risk assessment This review will continue for a		
					duration of 12 months.	1	
					Any concerns will be		
					addressed.		
	medication admi	nistration sheet indicated			The results of these reviews		
	for the month of	March received the			will be discussed at the monthly facility Quality		
	following amounts of fluid:				Assurance Committee meeting	ıg	
	3/22/2011 1560 1				and frequency and duration o	of	
	3/21/2011 780 m				reviews will be adjusted as		
	3/20/2011 1290 r				needed. Completion date: 4/24/11		
	3/19/2011 360 m						
	3/18/2011 1200 r						
	3/17/2011 1440 r						
	3/16/2011 2000 r						
	3/15/2011 820 milliliters 3/14/2011 60 milliliters 3/13/2011 540 milliliters 3/12/2011 1200 milliliters						
	3/11/2011 600 m						
	3/10/2011 720 milliliters						
3/9/2011 1290 milliliters							

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	1 ′	DER/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 03/25/2	LETED
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COM	MUNITY LLC	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN46237	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST B REGULATORY OR LSC IDENTI	E PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	3/8/2011 830 milliliters 3/7/2011 880 milliliters 3/6/2011 870 milliliters 3/5/2011 900 milliliters 3/4/2011 1410 milliliters 3/3/2011 820 milliliters 3/2/2011 1200 milliliters 3/1/2011 340 milliliters 3.1-35(g)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		A. BUILDING 00			COMPL	3) DATE SURVEY COMPLETED 03/25/2011	
NAME OF PROVIDER OR SUPPLIER ALTENHEIM HEALTH & LIVING COMMUNITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 3525 E HANNA AVE INDIANAPOLIS, IN46237				
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PERCEDED BY FULL DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
Based on observation facility failed to ensur covered and dated, ray not thawing over boxed was covered, and failed black mold was not grin the dietary departm potential of affecting who reside at the facility Findings include: During the tour of the conducted with the Dia 3/21/2011 at 10:00 a.r. observations were man a) In the salad refriger zip lock bag containing be fruit salad, did not b) In the tray line refriger bowels of grapes, 5 be sauce, and 5 slices of was not covered or date. c) The wall to the right behind where the dish loaded into the maching mold growing on the salad growing on the salad growing or the salad grow	re that food was whamburger was ed turkey, facial hair ed to ensure that rowing on the walls ent. This has the 69 out 69 resident ity. facility's kitchen fetary Manager on m., the following de: rator, a gallon size fig what appears to have a date on it. figerator, there was 3 owels of apple food cake, that ted. at of the dishwasher, first are loaded are fine, there was black wall. downstairs, had raw	F037	1	F371-483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY I. The bag containing fruit salad was discarded upon discover during the survey. The bowls of grapes, apple sauce and angel food cake were discarded upon discove during the survey The mold on the wall to the right of the dishwasher was immediately removed and cleaned during the survey. The box of turkey was immediately discarded and the cooler was rearranged so that no raw meat was thawing above other food items. The scoop was removed from the sugar and the sugar was discarded. Employee #1 and #2 were immediately educated on sanitary conditions and now have any facial hair appropriately covered. II. All opened food items are now appropriately covered and dated. The walls in the dietary department have been cleane and are free of black mold. All foods in the cooler are arranged so that no raw meat is thawing above other food items.	y ry e t	04/24/2011	

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NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE HANNA AVE	03/23/2011
ALTENH	EIM HEALTH & LIVI	NG COMMUNITY LLC	INDIAN	IAPOLIS, IN46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	e) A scoop was for container. f) Employee #1 a facial hair that is During an intervious Manager, on 3/25 indicated the blace	ound in the bulk sugar and Employee #2 had		Scoops are not left in bulk sugar containers. Employees with facial hair have their hair covered appropriately. III. The systemic change include a schedule of dietary staff wit assignments for daily checklists to include the Dietary Manager to hold staff accountable for the checklist Any newly hired kitchen staff will be trained on the daily checklist during orientation. The cleaning schedule has been reviewed and revised to include the items listed above Education was provided for a dietary staff regarding the dating and covering of opene foods, cleaning schedules for the dietary walls, arrangement of foods appropriately in the cooler so that no raw meat is thawing above other food items, scoops are not left in bulk containers, and proper covering of any facial hair. IV. The Director of Dining Service or designee will complete a daily audit, 5 days a week, of proper storage and dating of opened foods, cleaning of an visual checks of the dietary department for molds, proper covering of facial hair, no scoops left in bulk containers and appropriate arrangement	s th e. III d r tt es

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C OF CORRECTION IDENTIFICATION NUMBER: 155196	` ′	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2011
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY LLC	3525 INDI	ET ADDRESS, CITY, STATE, ZIP CODE 5 E HANNA AVE ANAPOLIS, IN46237	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
			of foods in the cooler so that no raw meat is thawing above other food items. This audit will continue for 30 days, and then will be completed 2 day week for an additional 60 day then one day a week for an additional 60 day then one day a week for an additional 60 day then one day a week for an additional 60 day then one day a week for an additional 60 day then one day a week for an addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meet and frequency and duration reviews will be adjusted as needed. Completion date: 4/24/11	ve t t d ys a eys,

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